

Coding Guidelines

Chiropractic Services, J3 CB2006.13 R1

The diagnosis must be subluxation (see ICD-9-CM Codes that Support Medical Necessity Section in this policy). Subluxation is defined as the incomplete dislocation, off centering, misalignment, fixation or abnormal spacing of vertebrae or intervertebral units. Subluxations are classified as either:

- Acute, such as strains and sprains;
- Chronic, such as loss of joint mobility; or
- Nerve root problems, such as a pinched nerve.

Use of X-rays:

An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

The x-ray must be made available to Medicare when requested. If the spinal x-ray(s) have been taken in a hospital or outpatient facility, a written report, including interpretation and diagnosis must be present in the patient's clinical record. The x-ray film(s) must be labeled with the patient's name and date the x-ray was taken, and must be marked right or left. The date of the x-ray must be entered in Item 19 on the CMS-1500 claim form or in the narrative field for electronic claims. (Effective for claims with dates of services on or after January 1, 2000, an x-ray is not required to demonstrate the subluxation. However, an x-ray may be used for this purpose if the chiropractor so chooses.)

If an x-ray is used, a physician who is an MD or DO must order it (Medlearn Matters article SE0416). Manual 100-2 Chapter 15, Section 240.1.1

Physical Exam:

In lieu of an x-ray, a subluxation may be demonstrated by physical examination meeting the requirements listed below:

- a. Pain/tenderness evaluated in terms of location, quality and intensity;
- b. Asymmetry/misalignment identified on a sectional or segmental level;
- c. Range of motion abnormality (changes in active, passive and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and

d. Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle and ligament.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under physical examination above are required, one of which must be asymmetry /misalignment or range of motion abnormality. Additionally, documentation requirements, discussed below, must be met.

The documentation of an exacerbation must be entered into the narrative field of an EMC claim or as an attachment with a CMS-1500 claim form.

Places of Service:

Manual spinal manipulations may be performed in the home, office, nursing home, skilled nursing facility, inpatient facility or outpatient setting.

Diagnoses Covered:

This policy requires two diagnoses for each subluxation, a primary diagnosis (nonallopathic, ICD-9-CM codes 739.0-739.5) and a secondary diagnosis from Categories I, II or III, this diagnosis being the cause of the subluxation. Since, after January 1, 1997, the chiropractor may bill for manipulations of up to five separate regions (a subluxation in each region), this diagnostic requirement may lead to five different primary diagnoses and five different secondary diagnoses.

The CMS-1500 claim form has space, in Item 21, for four diagnoses. Electronic submitters also have the option of submitting up to four diagnoses. Item 24E of the CMS-1500 claim form or the electronic equivalent will accept one of these four diagnoses, as the diagnosis that justifies the treatment/service reported. It follows then, that, since both paper and electronic claims cannot accept more than four diagnoses, and if three, four, or five regions were treated leading to six, eight, or ten diagnoses, the question will be asked as to which four diagnoses to put on the claim form.

For CPT code 98940, Chiropractic manipulative treatment (CMT), one or two regions, the claim form can accept the four diagnoses that may be appropriate. For CPT codes 98941 and 98942, the chiropractic physician should enter into Item 21 on the CMS-1500 claim form or the electronic equivalent, the two most clinically significant primary diagnoses and their two accompanying secondary diagnoses. Select the most significant primary diagnoses and enter one in Item 24E on the CMS-1500 claim form or the electronic equivalent.

We must emphasize the point that, even though the claim form will only contain the diagnoses for two regions treated, if CMT for more than two regions is being billed, the clinical record MUST document the reasons for treating the other regions.

Use of AT Modifier:

For services on/after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT (acute treatment) modifier to every claim that uses HCPCS 98940, 98941, or 98942. If you

do not use this modifier, your care will be considered maintenance therapy and will be denied because maintenance chiropractic therapy is not considered medically reasonable and necessary under Medicare.

For services that are maintenance therapy, you may wish to obtain an Advance Beneficiary Notice (ABN) from the beneficiary and also apply the GA modifier (to be used when you want to indicate that you expect that Medicare will deny a service as not reasonable and necessary and that you do have on file an ABN signed by the beneficiary) or the GZ modifier (to be used when you want to indicate that you expect that Medicare will deny an item or service as not reasonable and necessary and that you have not had an ABN signed by the beneficiary) as appropriate.

The precise level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis.

All ICD-9-CM diagnosis codes must be coded to the highest level of specificity (4th or 5th digit) and the primary diagnosis must be supported by x-ray or physical exam.